

Medicare
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**PAYMENT
SYSTEM
FACT SHEET
SERIES**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES



**Inpatient
Psychiatric Facility
Prospective
Payment System**



Under Section 124 of the Balanced Budget Refinement Act of 1999 (Public Law 106-113), the **Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)** for psychiatric services furnished to Medicare patients in psychiatric hospitals and distinct part units in acute care hospitals and Critical Access Hospitals was implemented effective January 2005.



The following requirements must be met in order for Medicare to pay for inpatient psychiatric hospital services:

- The patient must be furnished active treatment that can reasonably be expected to improve his or her condition;
- Services must be furnished while the patient is receiving either active treatment or admission and related services necessary for diagnostic treatment;
- A physician must provide certification at the time of admission or as soon thereafter as is reasonable and practicable that the patient needs, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of IPF personnel; and
- A physician must provide the first re-certification as of the 12th day of hospitalization and subsequent re-certifications at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses), but no less than every 30 days that the patient continues to need, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of IPF personnel.

Patients who are treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness with a 60-day lifetime reserve and for 190 days of care in freestanding psychiatric hospitals.

HOW PAYMENT RATES ARE SET

Under the IPF PPS, Federal per diem rates include inpatient operating and capital-related costs (including routine and ancillary services) and are determined based on:

- Geographic factors:
 - A hospital wage index value is assigned to account for geographic differences in wage levels; and
 - The non-labor related portion accounts for higher cost of living for IPFs located in Alaska and Hawaii;
- Patient characteristics:
 - Diagnosis Related Group (DRG) classification;
 - Age;
 - Presence of specified comorbidities; and
 - Length of stay; and
- Facility characteristics:
 - A 17 percent payment adjustment for rural facilities due to their higher costs; and
 - Teaching hospitals receive payment to account for indirect medical education costs.



Additional payments are provided for the following:

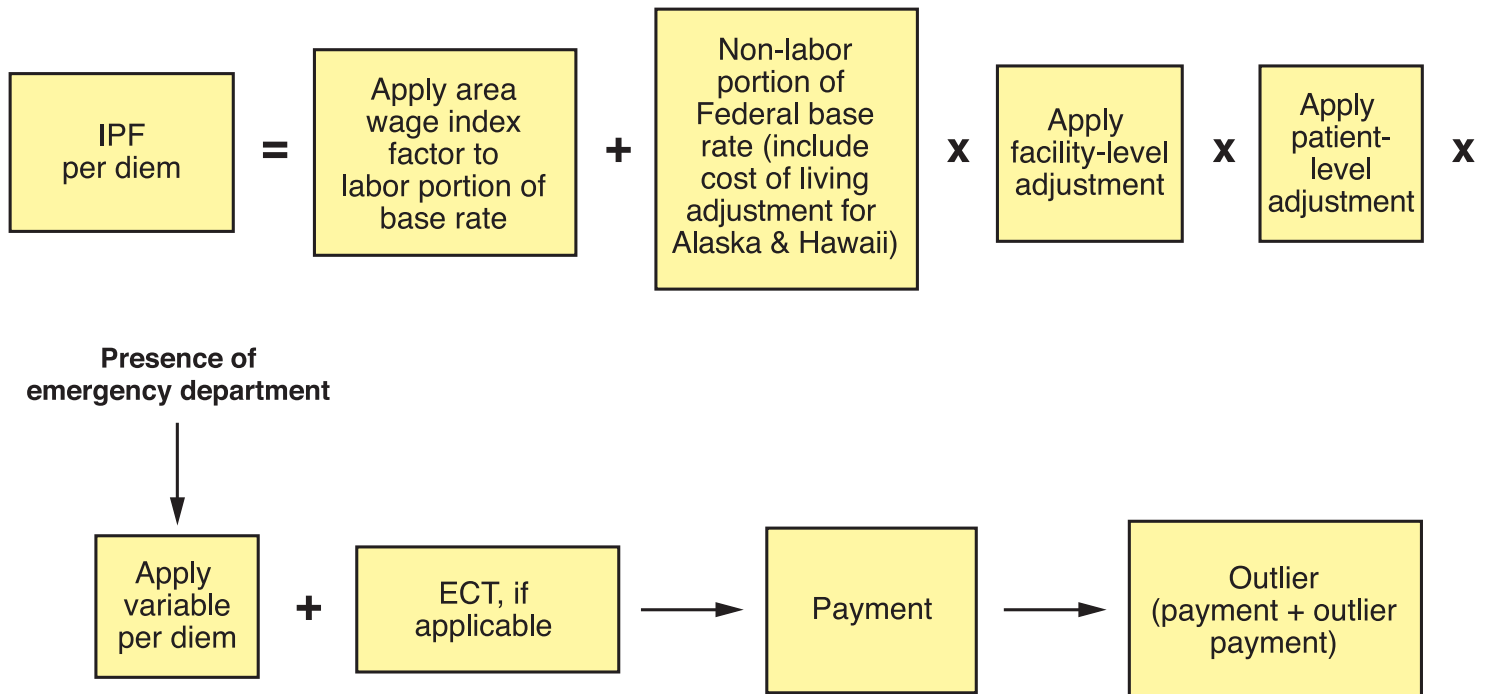
- Patients treated in IPFs that have a qualifying emergency department receive a 12 percent higher payment for the first day of the stay;
- The number of Electroconvulsive Therapy (ECT) treatments furnished; and
- Outlier payments for cases that have extraordinarily high costs (payment is for 80 percent of the costs above the threshold plus the estimated rate for days 1 through 8 and 60 percent of excess costs for the remaining days).

The per diem base rate excludes pass-through costs such as bad debts and graduate medical education.

IPFs are paid under the PPS according to their cost reporting year and transition into the PPS.

The transition to 100 percent PPS rates is complete for cost reporting periods beginning in 2008. During the transition, the stop-loss provision guaranteed that IPFs were not paid less than 70 percent of what they would have been paid under the Tax Equity and Fiscal Responsibility Act of 1982. This means that beginning January 1, 2009, all IPFs are receiving 100 percent IPF PPS payment and, therefore, the stop-loss provision is no longer applied. In the implementation year, the Federal per diem base rate and ECT rate were reduced by 0.39 percent to ensure that stop-loss payments were budget neutral. For Rate Year (RY) 2009, both the transition and stop-loss provision ended, and the rates were increased by 0.39 percent.

Inpatient Psychiatric Facility Prospective Payment System



RATE YEAR 2010 UPDATE

The RY 2010 update to the IPF PPS, which applies to IPF discharges that occur during the period July 1, 2009 through June 30, 2010, includes the following updates:

- Market basket update:
 - The Rehabilitation/Psychiatric/Long-Term Care market basket is used to update the Federal per diem base rate;
- Pricer updates:
 - Federal per diem base rate: \$651.76;
 - Fixed-dollar loss threshold amount: \$6,565;
 - Transition blend for cost reporting periods beginning on or after January 1, 2008: 100 percent PPS;
 - Labor-related share (75.889 percent): \$494.61;
 - Non-labor related share (24.111 percent): \$157.15; and
 - ECT rate: \$280.60;
- DRG and comorbidity adjustments;
- Fiscal year 2009 pre-floor, pre-reclassified hospital wage index and a wage index budget neutrality factor of 1.0009; and
- National cost to charge ratios (CCR) which apply to IPFs that have not yet submitted their first cost report, whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (the ceiling), or whose

Fiscal Intermediaries or A/B Medicare Administrative Contractors obtain inaccurate or incomplete data with which to calculate either an operating or capital CCR or both:

CCR	Median	Ceiling
Urban	0.5300	1.7647
Rural	0.6515	1.7381

To find additional information about the IPF PPS, visit <http://www.cms.hhs.gov/InpatientPsychFacilPPS> and the *Medicare Benefit Policy Manual* (Pub. 100-02) located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the Centers for Medicare & Medicaid Services (CMS) website.



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Medicare Contracting Reform (MCR) Update

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform/> on the CMS website.